Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ONE STEP DIAGNOSTIC INC
17320 READ OAK DR SUITE 100
HOUSTON TX 77090

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-0153-01

MFDR Date Received

SEPTEMBER `16, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position that (1) the services provided were certified by the carrier; (2) the services were certified to be provided at One Step Diagnostic, Inc.; and (3) there is no state mandate that we are aware of that would require these services be provided in an ambulatory surgery center (ASC) setting."

Amount in Dispute: $5,472.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider billed for primary CPT code 62311, lumbar injections. This is a surgical code according the AMA CPT codebook, and therefore is required to be performed in a facility appropriate to surgical procedures. The Provider herein did not bill on a UB-04, which indicates they are not a hospital setting. Consequently, the Carrier looked to the ambulatory surgical center licensing to determine if the Provider was an appropriately licensed surgical facility. The Provider holds no ASC license. The Carrier consequently determined the Provider was not an appropriate place of service for the procedures performed under the Medicare billing guidelines. Reimbursement was denied as the Provider did not hold an appropriate facility license for the services rendered. The Carrier contends the Provider is not entitled to reimbursement for the disputed services. The Carrier further believes the Provider should not be reimbursed as the performance of surgical procedures in an office setting is inappropriate. The Provider billed place of service code 11 (office) for the injections. The performing of surgical procedures in an office, without appropriate safeguards, constitutes a potential danger to the health and welfare of injured workers."

Response Submitted by: Travelers, 1401 S. Mopac Expressway, Ste. A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 12, 2001	CPT Codes 62311, 77003-26, 94760, 99070 HCPCS Codes A4649, J2001, J3301, J3010, J2250, J3490, Q9967	$5,472.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 23, 2011 and July 25, 2011
   - T104 – 184 – The prescribing/ordering provider is not eligible to prescribe/order the service billed. Provider is not licensed in Texas as an ASC.
   - T227 – S2 – The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed. The provider is not a licensed ASC provider.

Findings

1. The respondent denied the preauthorized services stating that the prescribing/ordering provider is not eligible to prescribe/order the service billed; the referring/prescribing/rendering provider is not eligible to refer/prescribe/order perform the service billed; and, the provider is not a licensed ASC provider. The respondent in their position summary states, **"**The Provider billed for primary CPT code 62311, lumbar injections. This is a surgical code according the AMA CPT codebook, and therefore is required to be performed in a facility appropriate to surgical procedures. The Provider herein did not bill on a UB-04, which indicates they are not a hospital setting." According to the American Association of Orthopedic Surgeons and the American Association of Professional Coders CPT Code 62311 can be performed in an office setting. The Center for Medicare/Medicaid does not address this issue; nor do the Texas Labor Code or Division rules. Review of the submitted documentation finds that the respondent did not support the denial reason; therefore, the disputed issues will be reviewed in accordance with the Texas Labor Code and Division rules.
2. In accordance with 28 Texas Administrative Code §133.307(e)(2), the Division may raise issues in the MDR process when it determines such an action to be appropriate to administer the dispute process consistent with the provisions of the Labor Code and Division rules. Per 28 Texas Administrative Code §133.307(c)(2)(E) requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: a copy of all applicable medical records specific to the dates of service in dispute. Review of the submitted documentation finds that the requestor did not submit copies of any medical records for review. No documentation was found to support the services as billed.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 29, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.